`Nisseth Urribarri, MD,FACOG

1-954-368-9656 1-954-368-9356 www.UniqueWellnessCenter.com

9750 NW 33rd Street, Suite 111
Coral Springs FL 33065

Unique Wellness Center

Date/Fecha:_____ Referred by/Referido por: Internet ¤ Friend/Amistad ¤ Doctor ¤

Name/Nombre:	Phone/ Teléfono:
Email Address/Correo Electrónico:	DOB/FDN:
Address/Dirección:	Instagram @

1. - What is the reason for your visit today? Cual es la razón de su visita de hoy?	
2.- Any specific issues you would like to discuss today? Usted necesita discutir algún problema en particular hoy?	¤ YES ¤ NO
IF YES / SI? - What problems would you like to address with your doctor? - Que problema quisieras discutir con su doctor?	
3.- When was your last Pap smear? Cuando fué su última Citología o Papanicolaou?	Was it Normal? ¤ YES ¤ NO Fué Normal?
4.- When was your last Mammogram? Cuando fué su último Mamograma?	Was it Normal? ¤ YES ¤ NO Fué Normal?
5.- When was your last menstrual period? Cuando fué su última Menstruación?	
6.- What Health Insurance do you have? Cual Seguro de Salud tiene usted?	Problem Visit: Copay : _____ Ded: _____ Coinsurance: _____
7.- Are you pregnant? Está usted embarazada?	

- If today is your wellness visit and you would like to discuss a problem with your doctor, you may have to book another appointment. Si hoy es su visita de bienestar y desea discutir un problema con su médico, es posible que deba reservar otra cita.

Caring for Women in all stages of Life

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Dear Patient,

You are scheduled for your Annual Women's Exam with one of our providers. The test is performed for a patient who has no symptoms/problems that need to be addressed by the provider. If an anomaly is found or a pre-existing problem is resolved in the process of performing this preventive drug evaluation and management service, and you would like the provider to address this, then and the additional office visit procedure codes, 99201-99215, will also be notified to your insurance.

If a problem is found and involves additional services (including lab work, genital cultures, urine test, urine pregnancy test, urine culture, and minor procedures in office, etc.), you may be responsible for an additional co-payment or deductible.

Our office will determine this at the end of your visit and collect any applicable money at that time or after your insurance company pays our office on your part.

By signing this notice, I verify that I have read the above and that my questions have been answered to my satisfaction. I understand that the money may be due before I leave this office.

Print Name:_____ D.O.B: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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Appointment Cancellation/No Show Policy

Our goal is to provide all of our patients with exceptional care. “No Shows” and late cancellations inconvenience those individuals who are in need of medical care. Therefore, we would like to remind you of our office policy regarding missed appointments.

Cancellation of an Appointment

In order to be respectful of the needs of other patients, please call us promptly if you need to cancel or reschedule your appointment. We require that you call twenty-four (24) hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to receive medical care in a timely manner.

As a courtesy, our staff will contact you via text, email or phone call forty-eight (48) hours in advance to confirm your appointment. We will leave a voice mail message if we are unable to reach you personally. If you are not able to keep your appointment, we will be happy to reschedule it for you. Please do give us a 24 hour advance notice to cancel or reschedule.

No Show Policy

A “No Show” is someone who is not present at the time of their scheduled appointment and has not provided adequate notification. We understand that emergencies may occur, however, when you do not call to cancel an appointment, you are preventing another patient from getting much needed treatment.

Charge for Late Cancellations and No Show’s

Failure to give a 24 hour advance cancellation or being a “No Show” will result in a non-refundable administrative charge of $50.00. This fee will not be covered by your insurance company.

If you have any questions regarding this policy, please ask our staff and we will be glad to clarify your questions. We thank you in advance for your cooperation and understanding.

Appointment Cancellation/No Show Policy

I acknowledge that I have been presented with the Appointment Cancellation/No Show Policy and that I understand the policy.

Patient Name	Patient Signature	Date